

A CASE OF CRURAL MONOPLÉGIA PROBABLY REPRESENT-
ING THE EARLY STAGE OF A UNILATERAL ASCEND-
ING PARALYSIS DUE TO DEGENERATION OF
THE PYRAMIDAL TRACTS.

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Four or five years ago I presented the records of two cases which seemed to me to constitute a new clinical type. One of these was a man in whose case a paralysis began in the right lower extremity and extended later to the upper and finally to the face. The other was a woman I had seen many years before, in whom the same order of events took place, paralysis beginning in the left leg and extending later to the left arm. I saw this patient several years afterwards and the paralysis had then gone to the other side. Dr. Spiller reported a similar case as did also Dr. Potts. Later Dr. Spiller and I presented a case with post-mortem findings which showed that the disease was due to progressive degeneration of the pyramidal tracts. Dr. Patrick also reported a case.

Recently in the suburbs of the city I saw a case which seems to belong to the same type, although it is at present one of crural monoplegia. Mrs. W., 50 years old, was seen in consultation in October, 1905. The patient, in August, 1904, first discovered some weakness of the right lower extremity, although it may have been present in mild degree before. The weakness and awkwardness in using the limb very gradually increased until about one or two months before coming under observation, since which time the physician in attendance says that the impairment has increased more rapidly. She had suffered no pain in the extremity, in the back or in the head, and had no symptoms of cerebral disease. She had occasional headaches which seemed to be of the migraine type, and now and then had slight vertigo, but this was probably due to either the condition of her stomach, or to some arteriosclerosis.

Examination showed that the patient had a rather wiry pulse. She was a stout woman with no detectable nervous affection except in the right lower extremity and possibly a very slight weakness in the upper; so slight as to be somewhat doubtful.

Examination of the right lower extremity showed general paresis of moderate degree in the entire limb, that is, all movements were impaired in force without definite localized palsy of any group of muscles. The movements of flexion, extension, abduction and adduction of the foot and also intermediate movements were distinctly impaired as compared with those of the left foot, but the reduction in power extended to the entire limb, although it appeared to be more marked distally. The right knee jerk was greatly exaggerated and patellar clonus could be elicited. Persistent ankle clonus was present on the right and also a decided Babinski response. Front tap was present and marked on the same side and the muscle jerks were also plus on this side. On the left the knee jerk was somewhat above the usual norm, as were also the muscle jerks, but patellar clonus and front tap were absent. The plantar response was irregular, the toes sometimes remaining still. At other times they went up in connection with the tarsal response, but not with a typical Babinski movement.

Careful examination was made for sensory disorders with absolutely negative results, cutaneous anesthesia in all its forms, muscular anesthesia and astereognosis being absent.

The case appeared to be an apparently motor affection best explained by degeneration of that portion of the pyramidal tract which passes from the motor cortex to the lumbo-sacral cord.

It is altogether probable that the disease in this case will eventually advance and involve the upper extremity of the same side, and also the unaffected lower extremity. Examination seemed to show some slight impairment of the upper extremity, but so slight that it was hardly fair to record it as present.